Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Prosthetics and Orthotics

Section A To be completed by physician

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____
Diagnosis	
Prognosis	
Functional Limitations	
Estimated Length of Need (Months) 1–99 (99=Lifetime)	
Date of Last Evaluation by Physician	**Physician's Name**

Section B Can be completed by prosthetist/orthotist

1. Is this the initial prosthetic/orthotic? ☐ Yes ☐ No
2. Purchase date of last prosthetic /orthotic?
3. Name, address, and telephone number of supplier.
4. List all modifications and growth adjustments made to this prosthetic/orthotic and date of such adjustments.
5. Can current prosthetic/orthotic be reused in all or in part to meet current needs? Please explain.
6. Narrative description of **all** items, accessories, sizes, and options to be included for this prosthetic/orthotic. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

   ☐ **Yes,** additional attachments **are** included. ☐ **No,** additional attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Signature and date stamps are not acceptable.

_____ _____

Physician's Signature **Date (mm/dd/yyyy)**